

Please complete this form and either fax to 1-888-878-8474, complete online at www.VyndaLinkPortal.com, or mail to **VyndaLink** at PO Box 221296, Charlotte, NC 28222.

If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

By enrolling in the **VyndaLink** program, patients will receive various forms of support and information to help access VYNDAMAX™ (tafamidis) and VYNDAQEL® (tafamidis meglumine), which may include the following, depending on the program (collectively, “patient support activities”):

- Providing benefits investigations/verification and reimbursement support, including assistance with identifying patient insurer requirements for prior authorization and appealing a denied claim
- Determining patient eligibility for and access to co-pay support or free drug programs
- Communicating with healthcare providers about VYNDAMAX, VYNDAQEL, and patient support activities
- Providing patients with financial assistance resources and information, if eligible
- Providing patients with disease management and other educational materials, as well as information about Pfizer’s products, services, and programs (which may include surveys about patient experience with Pfizer products, services, and programs)



ENROLLMENT CHECKLIST FOR PATIENTS

- Complete all required sections marked with an asterisk * on pages 2-4
- If you are seeking financial assistance, complete all financial information in section 2 and attach documentation of your total annual income, such as federal tax return, W-2, or other
 - If submitting a tax return, only include page 1 of IRS 1040 Form
- Provide copies of your insurance and prescription card(s)—front and back sides. If you are enrolled in Medicare, provide a copy of your medical and pharmacy cards
- Be sure to sign and date the Patient Authorization to Share Health Information (section 7), and if interested in Personalized Patient Support, check the box in section 6
- Make a photocopy of your enrollment form, as it will not be returned to you
- Ask your doctor to complete, sign, and submit the healthcare provider portion of the form (sections 8-12)



ENROLLMENT CHECKLIST FOR HEALTHCARE PROVIDERS

- Complete all required sections marked with an asterisk * on pages 5-7
 - Provide Prescription Information, including Directions/Dosing Instructions in section 9
 - Review Healthcare Provider Privacy and Consent in section 10
- Complete the Interim Care program prescription on pages 5-7 if your patient may need assistance through the Interim Care program
- Instruct patient to review and sign the enrollment form and Patient Authorization to Share Personal Health Information form
 - Retain the original signed form with the patient’s records and provide a copy to the patient
 - Medical records are not required; do not include in the fax
- Ensure all required fields are complete
- Fax the completed enrollment form to 1-888-878-8474

VyndaLink ENROLLMENT FORM: PATIENT



Complete this form and submit with copies of both sides of the patient's insurance cards. You can fax it to 1-888-878-8474 or mail it to **VyndaLink** at PO Box 221296, Charlotte, NC 28222. If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

For Patients Fields marked with * are required.

1. Patient Information			
Name (First, MI, Last)*		Gender* <input type="checkbox"/> Male <input type="checkbox"/> Female	
Date of Birth (mm/dd/yyyy)*	Email		
Street Address*			
City*	State*	ZIP Code*	
Primary Phone*	<input type="checkbox"/> OK to leave message	Language Preference	
<input type="checkbox"/> Patient Caregiver	Caregiver Name	Caregiver Phone	

2. Patient Financial Information (This information is required to search for alternate funding support and verify eligibility for the Pfizer Patient Assistance Program† as appropriate. If you complete this section, be sure to read and sign section 4 on the next page.) If you do not complete this section, VyndaLink cannot evaluate financial assistance resources for which you may be eligible.	
Total number of people within household (including applicant)	Total annual household income \$
Please submit documentation to support the financial information you've listed. Attached is: <input type="checkbox"/> Most recent federal tax return <input type="checkbox"/> W-2 form <input type="checkbox"/> Other	

3. Insurance Information (Please include a copy of both sides of your insurance and prescription card[s].)		
<input type="checkbox"/> Check here if patient does not have insurance <input type="checkbox"/> Check here if patient has secondary insurance		
Primary Insurance Name*		
Primary Insurance Phone Number*	Policy/Group #*	
Primary Policyholder Name (First, MI, Last) (if other than patient)*		
Primary Policyholder Date of Birth (mm/dd/yyyy)*	Primary Policyholder Relationship to Patient	
Is VYNDAMAX™ (tafamidis) or VYNDAQEL® (tafamidis meglumine) covered? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> I don't know If yes, what is the co-pay amount? _____ <input type="checkbox"/> I don't know		
Prescription (Rx) Insurance Name* (if applicable)		
Policy #*	Group #*	Rx Bin #*
If the patient is insured through a Medicare Prescription Drug Plan, please include the full plan address‡:		

†The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc., with distinct legal restrictions.

‡If you have a Medicare Part D plan and are eligible for the VyndaLink Interim Care program, VyndaLink will notify your Part D plan of your enrollment in the Interim Care program.

See next page to continue completing the patient section of the enrollment form.

VyndaLink ENROLLMENT FORM: PATIENT



Complete this form and submit with copies of both sides of the patient's insurance cards. You can fax it to 1-888-878-8474 or mail it to **VyndaLink** at PO Box 221296, Charlotte, NC 28222. If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

For Patients Fields marked with * are required.

4. Patient Consent for Pfizer Patient Assistance Programs (Required if you entered financial information in section 2.)

The information you provide will be used by Pfizer, **VyndaLink**, the Pfizer Patient Assistance Foundation™, and parties acting on their behalf to determine eligibility, to manage and improve Pfizer's assistance programs, to communicate with you about your experience with Pfizer's assistance programs, to help you understand your insurance coverage and help you access certain Pfizer medicines through your insurance, and/or to send you materials and other helpful information and updates relating to Pfizer programs.

I understand that:

Completing this enrollment form does not guarantee that I will qualify for Pfizer's assistance programs. Pfizer may contact my insurer, to help me understand my insurance coverage for certain products and may provide me support to obtain coverage through my insurer, including prior authorization and appeals assistance (if necessary and available). Pfizer may verify the accuracy of the information I have provided and may ask for more financial and insurance information. Any medicines supplied by Pfizer's assistance programs shall not be sold, traded, bartered, or transferred. Pfizer reserves the right to change or cancel Pfizer's assistance programs, or terminate my enrollment, at any time. The support provided through this program is not contingent on any future purchase.

I certify and attest that if I receive medicine(s) provided by Pfizer through the Pfizer Patient Assistance Program:

I will promptly contact the Pfizer Patient Assistance Program if my financial status or insurance coverage changes. I will not seek to have this medicine or any cost from it counted in my Medicare Part D out-of-pocket expenses for prescription drugs. I will not seek reimbursement or credit for the medicine(s) from my prescription insurance provider or payer, including Medicare Part D plans. I will notify my insurance provider of the receipt of any medicines through the Pfizer Patient Assistance Program. I have a signed copy of a current and completed HIPAA Authorization Form on record with my HCP so that my HCP may share health information about me with Pfizer's assistance programs, Pfizer Inc., and the Pfizer Patient Assistance Foundation, Inc. By signing the form, I certify that I cannot afford my medication, and I affirm that my answers and my proof-of-income documents are complete, true, and accurate to the best of my knowledge.

By signing below, I certify and acknowledge that I have read, understand, and agree to the above terms.

Patient Signature (Patient or Personal Representative of Patient)

Date

Sign here

5. Patient Consent to Receive Communications (optional)

By signing this form, I agree to communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. I agree to be contacted by Pfizer, **VyndaLink**, or parties working on their behalf for these purposes using an autodialer or prerecorded voice at the telephone number(s) provided. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, **VyndaLink**, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting **VyndaLink** at 1-888-222-8475.

Print Name of Patient

Patient Signature

Date

Sign here

6. Personalized Patient Support Opt-in (optional)

Personalized patient support is offered through **VyndaLink** via Patient Support Navigators. You can speak with Patient Support Navigators for resources that may help with your daily life. Your Patient Support Navigators may provide information about your condition, VYNDAMAX™ (tafamidis) and VYND AQEL® (tafamidis meglumine) medicine, or topics such as nutrition, as well as a co-pay card offer for eligible patients. Patient Support Navigators can also connect you to independent organizations that provide services such as transportation and lodging for your treatment-related appointments. These offerings may vary based on your prescribed medicine. To opt into this program, please check the box below.

- By checking this box, I request Patient Support Navigators' support and agree to communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf, including but not limited to autodialed and prerecorded calls to the phone number provided. These communications may include, for example, offers, resources, and other support such as those described above. I understand that my consent is not required or a condition of purchasing any Pfizer goods or services. I understand I can opt out of these communications at any time by contacting Pfizer at 1-888-222-8475.

See next page to continue completing the patient section of the enrollment form.

HIPAA AUTHORIZATION FORM FOR THE DISCLOSURE OF PATIENT INFORMATION BY PERSONAL PHYSICIAN

DO NOT FAX THIS HIPAA AUTHORIZATION FORM—IT IS FOR PATIENT AND HCP RECORDS ONLY



Fields marked with * are required.

7. Patient Authorization to Share Health Information*

By signing this form, I give my permission for my physicians, pharmacies, laboratories, and other healthcare providers (“Healthcare Providers”) and my health insurers to share my health information with Pfizer Inc., the Pfizer Patient Assistance Foundation, Pfizer affiliates and its vendors (collectively, “Pfizer”). I understand that my health information includes information relating to my medical condition, treatment, and insurance coverage, as well as identifying information about me (including, for example, my name, address, and date of birth). My health information will be shared with Pfizer so that Pfizer may provide me with various support and information to help me access a Pfizer medicine, which may include the following, depending on your program (collectively, “Patient Support Activities”):

- Providing benefits investigations/verification and reimbursement support, including:
 - Assisting with identification of your insurer’s prior authorization requirements
 - Assisting with identification of your insurer’s requirements for appealing a denied claim
- Determining my eligibility for and helping me access co-pay support or free drug programs
- Sending me a device and starter kit (where appropriate)
- Communicating with my Healthcare Providers about a Pfizer medicine and Patient Support Activities
- Providing me with financial assistance resources and information if I’m eligible
- Providing me with disease management and other educational materials, as well as information about Pfizer’s products, services, and programs, and may include sending me surveys about my experience with Pfizer products, services, and programs

Pfizer also may use my health information for quality assurance purposes and to evaluate and improve our operations and services.

I understand that I do not have to sign this form, and choosing not to sign will not affect my ability to receive

treatment from my Healthcare Providers or payment from my health insurer. However, if I do not sign this form, the **VyndaLink** program may not be able to provide me with assistance.

I understand that once my health information is shared, it may no longer be protected by federal privacy law. However, Pfizer agrees to protect my health information and to use it for the purposes described in this form or as required or permitted by law. Select pharmacies may receive remuneration from Pfizer in exchange for my health information and/or for any Patient Support Activities provided to me.

I understand that this form will remain in effect for 4 years from the date of my signature unless I provide written notice that I would like to withdraw my approval to share my health information sooner. If I would like to withdraw my approval, I may contact my physician or I may contact **VyndaLink** at PO Box 221296, Charlotte, NC 28222 or 1-888-222-8475. This withdrawal will not affect the use or sharing of my health information that took place before I withdraw my approval. I understand I may receive a copy of this form.

I also give my permission to receive communications from Pfizer, **VyndaLink**, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided to determine my eligibility and provide benefits verification, prior authorization/appeals assistance, and financial assistance resources and information, such as co-pay support or free drug programs, and for other non-marketing purposes. If I have a caregiver, he or she has also agreed to receive such communications from Pfizer, **VyndaLink**, and/or parties acting on their behalf for the purposes described above, and I hereby give my permission for Pfizer, **VyndaLink**, and/or parties acting on their behalf to contact my caregiver for such purposes. I understand that I (and, if applicable, my caregiver) can opt out of these communications at any time by contacting **VyndaLink** at 1-888-222-8475.

Print Name of Patient or Authorized Patient Representative*

Signature of Patient or Authorized Patient Representative*

Print here

Sign here

Relationship to Patient

Date*

Please retain the original signed Authorization with the patient’s records and provide a copy to the patient. You do not need to return this patient Authorization to Pfizer.

VyndaLink ENROLLMENT FORM: HEALTHCARE PROVIDER



Complete this form and submit with copies of both sides of the patient's insurance cards. You can fax it to 1-888-878-8474 or mail it to **VyndaLink** at PO Box 221296, Charlotte, NC 28222. If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

Fields marked with * are required.

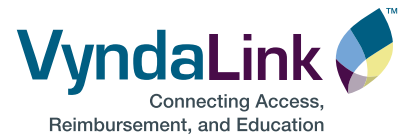
8. Healthcare Provider Information			
HCP Name (First, MI, Last)*		Practice/Institution Name*	Specialty*
Street Address*		City*	State* ZIP Code*
Phone*	Fax*	NPI #*	State License #*
Office Contact Name*		Office Contact Phone*	Email
9. Prescription Information: Two formulations are available: VYNDAMAX™ (tafamidis) and VYNDAQEL® (tafamidis meglumine). The recommended dosage is either VYNDAMAX 61 mg orally once daily (one 61 mg capsule orally once daily), or VYNDAQEL 80 mg orally once daily (four 20 mg capsules orally once daily). Please check all relevant boxes below if your patient would like to explore Interim Care eligibility.			
Patient Name (First, MI, Last)*		Patient Date of Birth (mm/dd/yyyy)*	
<input type="checkbox"/> I attest that my patient's diagnosis was confirmed.		Please list type of diagnostic test:	
Primary ICD-10 Diagnosis Code*		Secondary ICD-10 Diagnosis Code	
<input type="checkbox"/> I confirm that my patient is being prescribed VYNDAMAX or VYNDAQEL for the treatment of ATTR-CM.			
<input type="checkbox"/> Please check this box if your patient is currently participating in a tafamidis trial or compassionate use program.			
Drug Allergies: <input type="checkbox"/> No <input type="checkbox"/> Yes (If yes, please list medication(s) and associated reaction(s)):			
Patient's Concurrent Medications:			
Other Known Conditions:			
Prescription Refills # _____ <input type="checkbox"/> VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily, Quantity #30 capsules (30 days) OR <input type="checkbox"/> VYNDAQEL 80 mg: Four 20 mg tafamidis meglumine capsules orally once daily, Quantity #120 capsules (30 days)	Interim Care Program (for eligible patients insured by a commercial or federal insurance program) If eligible, free VYNDAMAX or VYNDAQEL may be provided at no cost if a delay occurs in the coverage determination process. Limits, terms, and conditions apply. [†] Patient may be additionally covered up to 60 days if eligible for refill. Prescription <input type="checkbox"/> VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily, Quantity #30 capsules (30 days) OR <input type="checkbox"/> VYNDAQEL 80 mg: Four 20 mg tafamidis meglumine capsules orally once daily, Quantity #120, capsules (30 days)	Pfizer Patient Assistance Program (for eligible uninsured/underinsured patients only) Patients must reapply annually. Limits, terms, and conditions apply. Only VYNDAMAX is available through the PAP. [‡] Prescription <input type="checkbox"/> VYNDAMAX 61 mg: One 61 mg tafamidis capsule orally once daily, Quantity #30 capsules (30 days)	
10. Healthcare Provider Consent and Signature*			
I certify that I am the healthcare professional who has prescribed the therapy identified in this form. I further certify that I have made an independent judgment that the above therapy is medically necessary and that the information provided in this form is accurate to the best of my knowledge. I authorize Pfizer, and its affiliates, agents, representatives, and service providers to act on my behalf for the purposes of transmitting this prescription to the appropriate pharmacy.			
Print Name of Healthcare Provider*			
Signature of Healthcare Provider* (NO STAMPS) (dispense as written)			Date*
Signature of Healthcare Provider* (NO STAMPS) (Product Substitution Allowed)			Date*

[†]See terms and conditions on page 7.

[‡]Criteria depend on a number of factors, including the specific medicine prescribed, insurance status, and household size and income. The Pfizer Patient Assistance Program is a joint program of Pfizer Inc. and the Pfizer Patient Assistance Foundation™. The Pfizer Patient Assistance Foundation is a separate legal entity from Pfizer Inc., with distinct legal restrictions.

See next page to continue completing the patient section of the enrollment form.

VyndaLink ENROLLMENT FORM: HEALTHCARE PROVIDER



Complete this form and submit with copies of both sides of the patient's insurance cards. You can fax it to 1-888-878-8474 or mail it to **VyndaLink** at PO Box 221296, Charlotte, NC 28222. If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

For Healthcare Providers

Note: In addition to completing this section, New York prescribers must submit a prescription on an original NY state prescription blank. Prescribers in all other states only need to submit a state-specific blank if it's required in their state, and the application is mailed.

11. Healthcare Provider HIPAA and TCPA Attestation

By my signature, I certify that I have obtained any and all authorizations and consents from the patient or the patient's authorized personal representative necessary under HIPAA and state law to release protected health information, including that contained on this form, to Pfizer and its employees or agents for purposes relating to Pfizer's patient support programs, including assisting the patient with benefits verification, prior authorization/appeals assistance, including contacting the patient's insurer to obtain status information, financial assistance resources and information, such as co-pay support or free drug programs, for which the patient may be eligible, and other support for VYNDAMAX™ (tafamidis) or VYNDAQEL® (tafamidis meglumine).

I certify that I have obtained consent from the patient or the patient's caregiver to be contacted by Pfizer, **VyndaLink**, and/or parties acting on their behalf using an autodialer or prerecorded voice at the telephone number(s) provided regarding the purposes described above and for other non-marketing purposes. I also give permission to receive calls related to these services from Pfizer, **VyndaLink**, and parties acting on their behalf, including calls made with an autodialer or prerecorded voice at the phone number(s) provided.

Signature of Healthcare Provider

Date

Sign here

VyndaLink ENROLLMENT FORM: HEALTHCARE PROVIDER



Complete this form and submit with copies of both sides of the patient's insurance cards. You can fax it to 1-888-878-8474 or mail it to **VyndaLink** at PO Box 221296, Charlotte, NC 28222. If you have questions, please call 1-888-222-8475, Monday-Friday, 8 AM-8 PM ET.

VyndaLink Interim Care

The Interim Care program may provide new, eligible patients with up to 60 days of free VYNDAMAX™ (tafamidis) or VYNDAQEL® (tafamidis meglumine) shipped directly to patients who have provided a completed Interim Care program VYNDAMAX or VYNDAQEL prescription and who have experienced a delay in coverage determination of 5 or more business days from the submission of a prior authorization or appeal directly to the patient's insurer.

For patients who have a Medicare Part D plan and are eligible for the **VyndaLink** Interim Care program, **VyndaLink** will notify the Part D plan of the patient's enrollment in the Interim Care program.

For Healthcare Providers Fields marked with * are required.

12. Prescriber Consent to VYNDAMAX or VYNDAQEL Terms and Conditions*

Date authorization/appeal request was made to the patient's insurer:

Interim Care Program Terms and Conditions

- Interim Care is not health insurance and is only available for eligible patients who are insured through a commercial or federal insurance program.
- Offer is only available for patients new to therapy (excluding any participation in a clinical trial) who have a valid prescription and an on-label diagnosis for VYNDAMAX or VYNDAQEL.
- Interim Care is only for new patients whose authorization and/or appeal has been requested/submitted to the patient's insurer and who have experienced a delay in coverage determination of at least 5 business days from the submission of a prior authorization or appeal directly to the patient's insurer.
- Patients who qualify for co-payment assistance from another Pfizer Patient Assistance Program are ineligible.
- Neither the patient, nor the pharmacy or anyone else acting on the patient's behalf, may submit any claim for reimbursement for product dispensed pursuant to this Interim Care program to any third-party payer, including Medicare, Medicaid, or any other federal or state healthcare program. Out-of-pocket expenses incurred when using this program cannot be applied toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).
- The product provided in the Interim Care program is free of charge and the patient should not be billed by anyone for this product.
- If the patient is enrolled in a Medicare Part D plan, they must provide the address of their plan in order to be eligible for the Interim Care program.
- Available in 30-day supply. Refills are subject to limitations.
 - To be eligible for an additional 30-day refill, the patient must be actively pursuing coverage through their insurance awaiting a prior authorization/appeal decision. Interim Care for VYNDAMAX or VYNDAQEL may not exceed 60 days for any patient.
- Interim Care offer does not require, nor will be made contingent on, purchase requirements of any kind.
- Pfizer reserves the right to amend, rescind, or discontinue this program at any time without notification.
- Interim Care can only be dispensed by the exclusive pharmacy and only after benefits investigation has been completed and a delay has occurred in the prior authorization or appeals process.
- Offer good only in the US and Puerto Rico.
- Prescription must be provided by a healthcare provider licensed in the US or Puerto Rico.
- Additional eligibility criteria may apply. Contact **VyndaLink** for details.

I confirm that my patient is new to VYNDAMAX or VYNDAQEL therapy and currently has a pending authorization/appeal with their insurer if I have provided the date the authorization and/or appeal request was made above.

I attest to the accuracy of the information provided on this form, including the date the authorization/appeal request was made to the patient's insurer to request coverage for VYNDAMAX or VYNDAQEL if already completed.

I consent to the Terms and Conditions of the Interim Care program and attest that I will not submit any claim for reimbursement for product dispensed pursuant to this Interim Care program to any third-party payer, including Medicare, Medicaid, or any other federal or state healthcare program. Out-of-pocket expenses incurred when using this program cannot be applied toward any government insurance benefit out-of-pocket spending calculations, such as Medicare Part D True Out-of-Pocket Costs (TrOOP).

Prescriber Signature*

Date*

Sign here